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**IN-HOME HEALTH CARE AND
HOSPITALIZATION STATUS**

**A Thesis
Presented to the
Faculty of
California State University,
San Bernardino**

**In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work**

**by
Donna Lee Maeser**

June 1996

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HOSPITALIZATION STATUS

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June 1996

Approved by:


Rosemary McCaslin, Ph.D., Thesis Advisor

6/12/96
Date


Teresa Morris, Ph.D., Chair of Research Sequence,
Department of Social Work


Brigette Castaneda, RN, BSN
Director of Patient Care, Nations Health Care

ABSTRACT

The purpose of this thesis was to describe the relationship between in-home health care services, for the elderly, over sixty five, recently discharged from in patient care and hospitalization status.

The sample included one hundred ninety patients for a seven month period which included variables of patient's gender, in-home health care status and hospitalization status.

The results showed a statistically significant relationship between in-home health care status and hospitalization status. The provision of in-home health care does mitigate a decline in health status of elderly patients, following discharge from inpatient care and reduces the chances of re-hospitalization.

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In this acknowledgment, I wish to first recognize and appreciate the patience and encouragement of my advisor, Dr. McCaslin, Director of the Department of Social Work, at California State University, San Bernardino, California, who expertly guided and encouraged me through this project.

Dr. Cardona deserves special acknowledgment due to her expert leadership in assisting me with the very beginnings of this project wherein she assisted me to formulate my ideas concerning in-home health care issues. She was a constant support and believed in me.

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INTRODUCTION

Problem Statement

The aging of America is the result of two demographic trends: rising life expectancy and declining fertility. Rising life expectancy rates have led to increased longevity and a greater number of older adults. The drop in fertility rates has reduced the number of younger persons relative to the elderly. Together, these factors have led to an older population that is both absolutely and relatively the largest and fastest growing population in America's history (Dychtwald, Zitter and Levinson, 1990).

The America of past was a young nation. Aging and care for the elderly were not major issues because most people died at a relatively young age. According to the Census Bureau, in 1900, only three million Americans, that is one out of every twenty five persons, was over age 65. A baby born during that year could expect to live 47.3 years; the average 65 year old would not reach 77. The median age was 22.9 and only two fifths of the population could expect to reach age 65 (Ward and Tobin 1987).

Old age in 1900 usually meant late fifties or early sixties. More than half of all persons over 55 were under 65. Of those over 65, nearly three-fourths were under 75. There were fewer than 125,000 persons aged 85 or more, representing just 0.2 percent of the total population. The elderly accounted for only 4 percent of the entire population and only 7.6 percent of all adults (Ward, and Tobin 1987).

Turn of the century America was a youth centered culture and the elderly tended to be ignored. Over three-fourths of the population was under the age of 40, and since elderly persons were fewer in both absolute numbers and relative proportions, social systems and structures were oriented predominantly toward the young and productive. There was little need to design facilities or create support programs for the elderly that would include health services, because disease or accidents killed the average person before he or she reached age 50.

As breakthroughs in health care, improved diet and better living conditions increased so did the numbers of Americans who lived longer; the nation began to age, but the rate of change was moderate. By 1940, there were nine million Americans age 65 or

over, accounting for 6.8 percent of the total population and 10.7 percent of all adults. A baby born that year could expect to live 62.9 years, on the average. The relative age segments within the over 55 population had changed very little since 1990: more than half of that group was still below age 65, and more than 85 percent were under age 75. Old age had now become somewhat more common (Dychtwald, Zitter and Levison, 1990).

Subsequent decades saw a dramatic rise in the numbers of older people. Between 1940 and 1970, the number of Americans over age 55 increased by 75 percent, while the number of persons over age 65 more than doubled. By 1970, nearly one in ten Americans was over age 65, and the nation had become home to almost 20 million elderly persons.

It was during this period that America finally began to notice its elderly. The Older Americans Act of 1965 established the U. S. Administration on Aging and that same year saw the passage of Medicare legislation designed to provide medical assistance for persons over 65. Life expectancy now had reached to 70 years. Currently, more than two-fifths of the elderly have passed age 75. There are over three million Americans age 85 or over, which is 25 times more than in 1900.

During the past century, chronic disease has replaced illness as the dominant type of health problem among the elderly. Ironically, some claim that medical science's success in sharply curtailing acute infectious disease has contributed to the aging of the population. At the same time, illness patterns within an individual's life have changed: acute disease becomes less frequent with age, while chronic conditions are increasingly prevalent (Ward and Tobin, 1987). Thus there has been an increase in the proportion of the average life span occupied by chronic disease and a greater need for medical care and health service providers in later years.

Most visits to the hospital, by older persons, are for chronic conditions. Heart disease and other circulatory problems, diseases of the digestive and respiratory systems, and cancer are the leading causes of hospitalization among the elderly currently. These conditions also account for nearly three-fourths of elderly restricted activity days.

Chronic, degenerative diseases are the predominant health issues of the elderly and, increasingly, of an aging society (Cole, 1990).

Traditionally, acute care medical providers have focused on direct services. Patients come under their care, receive treatment, and are discharged from the setting. This is changing with eldercare; since older adults may require a continuum of care, quality becomes a system-wide issue involving multiple sites, transfers among them and the need for a coordination of all these efforts. Support services serve personal and supportive needs of the individual. Multiple dimensions of both support networks and social support are important for understanding the nature and impact of interpersonal relationships on personal well-being.

Social support has been defined as information leading people to believe that they are cared for and loved, are esteemed and valued, and belong to a network of communication and mutual obligation (Gooding and Jette, 1985). Social support is a broad term that includes the quantity and interconnectedness of a web of social relationships in which a person is embedded, the strength of those ties, the frequency of contact, and the extent to which the support system is perceived as helpful and caring (Bergman, 1990). For the very old, and the ill, social support plays a major role in maintaining well-being and fostering the possibility to transcending the physical limitations that often accompany aging.

Social support contributes to health and well-being in three ways. The first is that social support systems involve meaningful social relationships and reduce isolation. The second is that the presence of caring others provides a flow of affection, information, advice, transportation, assistance with meals and daily activities, finances and health care, all of which are critical resources. Finally, the presence of a support system which tends to reduce the impact of stress and to protect the elderly from some of the consequences of serious illness, such as Alzheimer's disease (House, 1985).

Supporting the optimal functioning of elderly people with illnesses requires an individualized approach. Each person has a unique profile of competencies and

limitations. Many creative strategies have been introduced that have permitted people to stay at home and function at a high level of well being and independence.

Social support has a price tag. The elderly consume a disproportionately large share of America's health care. Persons over 65 accounted for 12 percent of the population in 1984, but used nearly 31 percent of all personal health care expenditures, according to the Health Care and Financing Administration (HCFA). Most of the health care for older Americans is purchased with government dollars. Federal and state governments reimburse health care through Medicare and Medicaid programs, and local governments own and operate county hospitals and other facilities.

We need to study trends in health care for the elderly as health care shifts more into community based care. Strategic planning is an act of making decisions in the present about the future of health care, which includes defining and setting goals, commitment and leadership to the increasing care needs of the elderly in America.

This study focused on the social support provided through in-home health care. The purpose of this study was to evaluate eldercare needs, specifically after discharge from an inpatient hospital stay and to define support networks and their effectiveness in preventing re-hospitalization of the elderly. The evaluation of social support practices is an integral aspect of in-home health care, informal, and formal support groups. Social workers provide information services, case management, community resource planning, information and referral, care options and provide a crucial link between needed care and existing services available in the community.

Problem Focus

To summarize briefly, the research question was "Does the provision of in-home health care following discharge from inpatient care, mitigate a decline in the health status of an elderly patient and prevent re-hospitalization?"

All of the information provided in this research project contributed to the evaluation of social work practice by allowing social workers to be informed, aware, knowledgeable and on the cutting edge of health care reform that is sweeping the nation

currently. We must place ourselves in a strategic position, in a master plan, for providing adequate eldercare services over the next decade and beyond.

Literature Review

It appears that there are different factors effecting the delivery of in-home health care services. One such factor is finances. The last year of a person's life tends to be the most expensive one, as shown in a recent HCFA study of Medicare enrollees that compared beneficiaries who died in 1978 with those who survived the year. Enrollees who died comprised 6 percent of the beneficiary group and 28 percent of the reimbursement expenditures, therefore consuming four times as many dollars of care as those who survived. Hospital discharge rates were over five times as high for those who died as those who survived. Care days per 1000 enrollees were almost seven times higher. Thus, higher per capita health care expenditures among the elderly are largely the result of that age group's higher death rates, which are disproportionately more expensive in the last year of an elderly patients life, according to HCFA.

Most of the health care services for older Americans is purchased with government money. In 1984, Medicare was the single largest source of personal health care funding for the elderly, with expenditures nearing \$60 billion. Since the Medicare and Medicaid programs were introduced in the mid-1960's, government funds have accounted for an increasing share of total health care expenditures for the elderly. However, because of rising costs, this growth in government spending has not significantly reduced the burden of medical expenses for elderly Americans. Formal in-home health care is growing rapidly. During the 1970's in-home health care expenditure growth averaged an unprecedented 31 percent per year, according to HCFA.

Other existing research by Perlman, et al. (1990) addresses the "Delivery of Home Care Services After Discharge, What Really Happens" which reports that social workers in hospitals develop discharge plans for in-home patient care with little systematic feedback about post-discharge implementation. A telephone follow-up study of patients discharged from an urban teaching hospital in 1990 was undertaken to determine the

extent to which discharge plans for in-home health care services were carried out and to identify factors associated with unsuccessful implementation of those services.

Overall, 72 percent of the patients received all planned services, 19 percent received some services, and 9 percent received none of the planned in-home care services. Great variability was found in service delivery: Registered nurse visits was the most successfully delivered type of service; 24-hour companions was the least successfully delivered service. Further, over one-third of patients experienced termination or reduction of services between discharge and the follow-up interview 21 to 28 days after discharge. Such unexpected and varied outcomes suggest the need for development of discharge follow-up programs that move beyond hospital walls to ensure that patients receive needed services.

In-home health care services encompass professional services provided by visiting registered nurses; physical, occupational and speech therapists; social workers and providers, such as home attendants, home health aides, hospice personnel, licensed vocational nurses, housekeepers or homemakers, and personal companions. Overall patterns indicate that discharge plans were more successfully implemented for services directed at meeting short-term acute medical needs than for those meeting personal and household chores.

Within formal in-home health care services social workers can be instrumental in preventing re-hospitalization by assisting patients in coming to terms with the implications and meanings of their illness whereas retention of the sick role hastens deterioration and can represent a health hazard. The patient must learn how to make use of those parts of themselves not affected by the disease and develop a new long term identity as part as secondary appraisal in order for effective coping to occur (Parver, 1995). Concurrently families can be instructed how to restructure roles and functions wherein there is potential for therapeutic interventions that may have long term beneficial effects for the patient and reduce re-hospitalization.

There has also been some legislation that positively effects utilization of in-home health care services, in order to decrease hospitalization days. Starting January 1, 1995, the Health Care Financing Administration (HCFA) has recognized physicians overseeing of the in-home service care plan as a separate and reimbursable activity. This is the first time that HCFA has acknowledged not only the importance of physicians managing their own in-home care patients, but the time involved, and the importance of after care at the time of in-home care in order to prevent re-hospitalization and the provision of a continuum of services.

The care plan oversight for in-home health care services requires recurrent physician supervision of therapy involving 30 minutes or more of the physician's time each month. The patient is required to have complex or multidisciplinary modalities involved which require the medical doctor to develop and revise the care plan, review subsequent reports of the patient status, review of lab and other reports, communicate (including phone calls) with other health care professionals involved in the patient's care, integrate new information into treatment plans or adjust medical therapy in order for the patient's in-home health care plans to be met and re-hospitalization discouraged.

Now that HCFA has addressed and implemented plans for increasingly improved coverage for in-home care services and oversight, the physician will have greater incentive to collaborate effectively with the in-home health services staff for the benefit of the patient. This is a great opportunity for all health care professionals, caring for the patient, at home, to improve the overall quality of care and services while decreasing the risk of re-hospitalization. To date, formal studies on re-hospitalization have used clinical diagnosis to predict and avoid costly re-admissions (Gooding and Jette, 1985). However, other studies have found that re-hospitalization could be avoided if patients received appropriate discharge planning according to Lockery (1994).

Placement planning and re-hospitalization have special importance under the prevailing Medicare pressures to shorten hospitalization. In 1983, Medicare cost containment efforts led to the use of the prospective payment system and diagnosis related

group classification (DRG). Lohr and Schroeder (1990) speculated that elderly people would be discharged too soon and in poorer health, thus leading to spiraling hospital costs as a result of re-hospitalization. According to the U.S. Congress, Senate Special Committee on Aging (1989), older adults are often discharged from acute-care hospitals early because of the DRG system, thus leading to re-hospitalization. Re-hospitalizations already account for 24 percent of Medicare expenditures among hospitalized patients (Andersen and Steinberg, 1984). Because Medicare funds most older adults' hospital care, the impact of DRG's on the discharge planning process is an important issue for medical social work.

Hospitals faced with constant pressure to shorten length of stay and diversify services are contracting with in-home health care service agencies to form an integrated delivery service approach. This managed care approach looks at the integrated delivery system of health care which involves hospitals, physicians, in-home health care providers, outpatient providers, insurers and Medicare to accept financial risk and provide care for a given population. There would also be provided an access to a full continuum of services which focus on primary and preventive care, broad geographic coverage, integrated information systems, demonstrated quality and outcomes with value based pricing, according to Parver (1995).

Re-hospitalization is also influenced by the older person's health and social status prior to hospitalization and the patient's perception of the family environment, professional involvement while the patient is hospitalized, patient involvement in decision making process and the type of discharge placement made (Lockery, 1994).

According to McCaslin (1988) another strong determining factor among the elderly is having knowledge of the service systems and self-perception of that system as having potential for oneself. This may be a relatively strong predictor of service use related to hospitalization, re-hospitalization and the utilization of in-home health care services. McCaslin (1989, p. 170) concluded that "General awareness of and positive orientation to the service system as a potentially relevant source of individual support

appears to be a critical influence on service use for all sub-groups of elderly, and especially among the well elderly. The conditions that create this orientation (and their stability across cohorts) are less clear and are an important issue for future research.”

Langer (1983) noted that “When people feel they can exercise some control over their environment, they seek out new information, plan, strategize, and so on - they behave mindfully and, as they engage in control behavior, it is this mindful enactment of perceived control behavior that yields... positive psychological and physical consequences... This is most clearly represented in the control intervention used with elderly populations” (p. 207-208). Furthermore, as Langer (1983) has also suggested, increase in real environmental control was related to increases in self-esteem. These findings, therefore, suggest that modest environmental manipulations that increase the control of elderly patients over their living environment, and the subsequent supports such as in-home health care and involvement in discharge planning may significantly increase their psychological and physical well-being, which may reduce re-hospitalization.

By discharging patients to their homes earlier than in the past, managed care is fueling physician involvement in the home and today’s in-home care involves far more acute care than ever before. Some physicians have limited knowledge of in-home health care services and the varying procedures such as blood draws, X-rays and EKG’s that now may be done within the in-home care setting. Some physicians may also lack familiarity with some of the most basic elements of in-home health care such as bedside commodes or shower bars which may have a significant impact on the patient, according to Parver (1995).

This transition for the physician, the patient and the family involves education and information for the in-home health care agency to be as effective as possible within the managed care guidelines. Medicare guidelines should address the patient’s best health care needs, therefore reducing re-hospitalization.

The re-emergence of education within in-home health care is truly a return to the industry’s roots. In the late 1800’s, visiting nurse associations were formed to deliver

patient education and caregiver training. And in the late 1900's in-home health care providers are again looking at strategically expanding the capacity in these areas (Hoss, 1995).

This return to education is in response to the fact that it is much less expensive to train the patient and family in effective procedures than it is to have professional clinicians provide the care. Self-care can be used effectively in a wide range of patients. What was the norm for in-home health care 100 years ago is becoming the competitive advantage in managed care today.

Technology will also be incorporated into education to support the patient who has received in-home care training. In the next few years, remote monitoring and telemetry devices will provide ongoing patient status information. In fact, the technology already exists to replicate the monitoring equipment of a hospital intensive care unit and place it in the home. Such systems can provide regular or periodic patient status feedback to office base stations monitored by clinicians. Over the next few years, the use of such equipment will become much more common, particularly for complex or unstable patients. The hospital of the year 2000 will be nothing but acute beds according to Hoss (1995). In-home care will have to be the hospital of the late 70's, where long term chronic diseases are treated. Ultimately, consumer demand, managed care and outcomes research will demonstrate the benefits of in-home health care services (Hoss, 1995).

RESEARCH DESIGN AND METHODS

Purpose of the Study:

The purpose of the study was to describe the relationship between in-home health care services for elderly patients who were recently discharged from inpatient care and re-hospitalization rates. The design was descriptive and the hypothesis was that the provision of in-home health care services would mitigate a decline in the health status, of an elderly patient, following discharge from inpatient care and prevent re-hospitalization.

This was a retrospective, one group design, that looked at outcome measurements for patients who received in-home health care services and those who did not receive in-home health care services.

Sampling:

The sampling was from the records of a provider of in-home health care services in the Inland Empire. Data was extracted for patients who were 65 or older and had been discharged from in-patient care with orders for in-home health care services. The time period covered was from July 1995 through January 1996. There were approximately one hundred ninety patient files reviewed for data input.

Data Collection, Instruments and Procedures:

A Data Abstraction Form was created, which included patient's age, gender, discharge destination, whether in-home health care services was actually received, and whether re-hospitalization occurred. The levels of measurement were nominal for all variables except age. The dependent variable was re-hospitalization.

The data were extracted from patient records and evaluated on a newly constructed instrument form. The weakness or limitation may present itself, if in the transference extracted data were incorrectly deposited in the incorrect cell, therefore producing incorrect data collection. The strength of the data collection method is that the information presented on the data abstraction form was easily read and limited confusion.

Protection of Human Subjects:

The patients included in this research study were evidenced by a hospital number and possessed no identity in the form of a name, address or social security number. There was no way to identify any patient in the research study. A number was assigned to each case and used as the reference identification number in the data abstraction form.

RESULTS

Description of Sample:

As can be seen in Figures 1, 2, and 3, of the one hundred ninety patients, one hundred thirty three (70%) were female, and fifty seven (30%) were male. There were one hundred seventy four (91.6%) patients who received in-home health care, while

sixteen (8.4%) did not receive in-home health care. There were forty three patients who were re-hospitalized and one hundred forty six (76.8%) who were not re-hospitalized. One patient's re-admission status was missing.

Figure #4 shows that there was a statistically significant relationship between in-home health care status and re-hospitalization status (chi-squared = 4.38, d. f.=1, P=.014). The data indicates that having received in-home health care was significantly associated with a lowered chance of being re-hospitalized. For the patients who did not receive in-home health care, the number of re-hospitalizations was greater than expected (7 as opposed to 3.6), while for those patients receiving in-home health care the number of patients not re-hospitalized was lower than expected.

Figure #5 shows that proportionally more females received in-home health care than males. This proportional difference was statistically significant (chi-squared = 5.94, d. f. =1, P=0.015).

Figure #6 shows that no significant relationship could be discerned within this sample between gender and re-hospitalization status, i.e., it cannot be said whether males or females were proportionally re-hospitalized more often (chi-squared = .736, d. f. =1, P=.390).

The size of this sample did not allow simultaneous evaluation of the effects of both gender and in-home health care on re-hospitalization status.

Figure #1
Patient's Gender

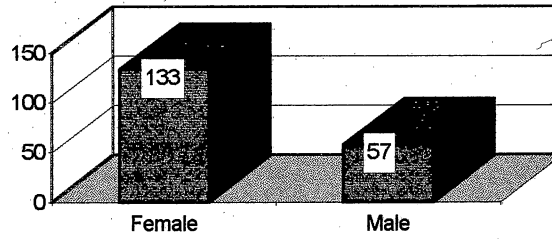


Figure #2
In-Home Health Care Status

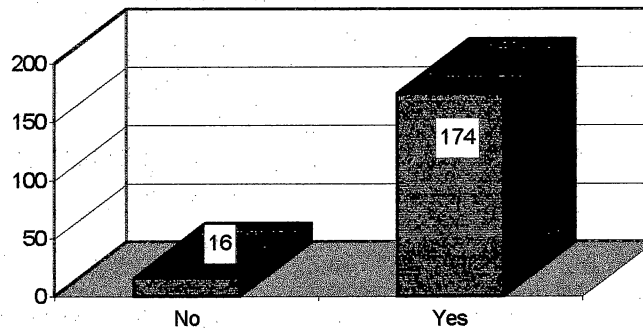


Figure #3
Re-Hospitalization Status

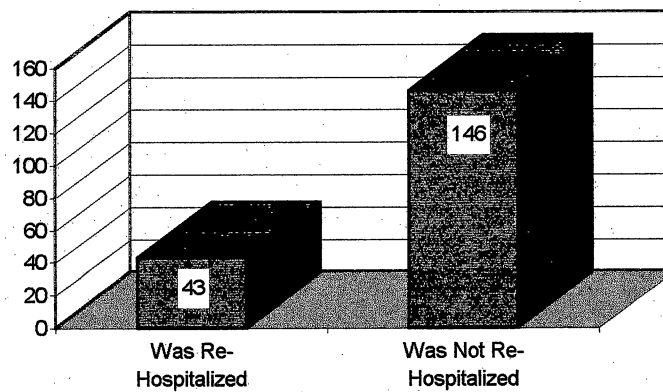


Figure #4 In-Home Health Care by Re-Hospitalization

	RE-HOSPITALIZED	NOT RE-HOSPITALIZED	TOTAL
Received In-Home Health Care	36	136	172
Did Not Receive In-Home Health Care	8	10	18
TOTAL	44	146	190

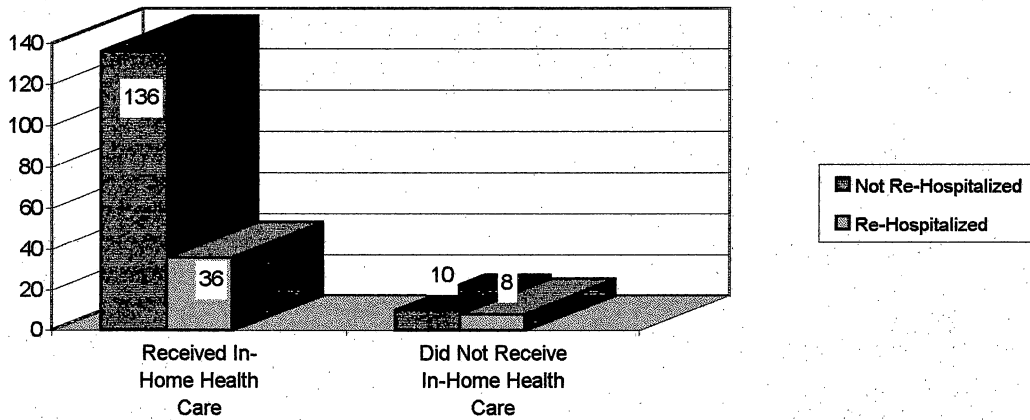


Figure #5
In-Home Health Care by Gender

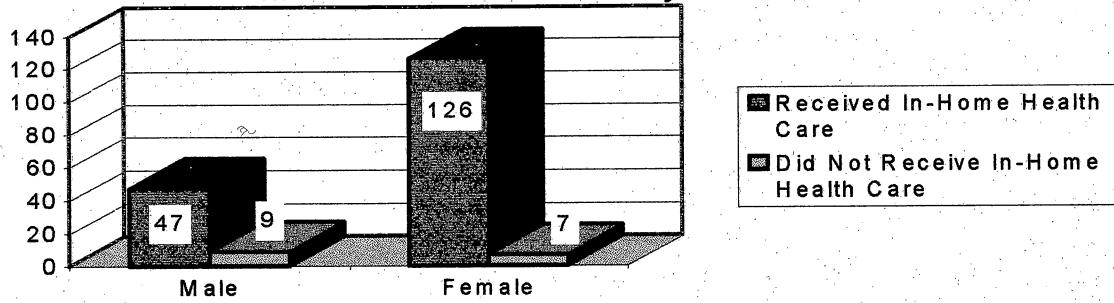


Figure #6
In-Home Health Care by Hospitalization Status

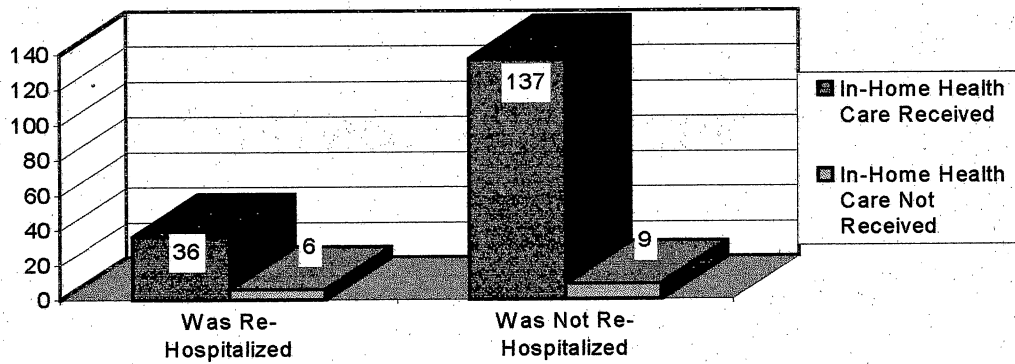
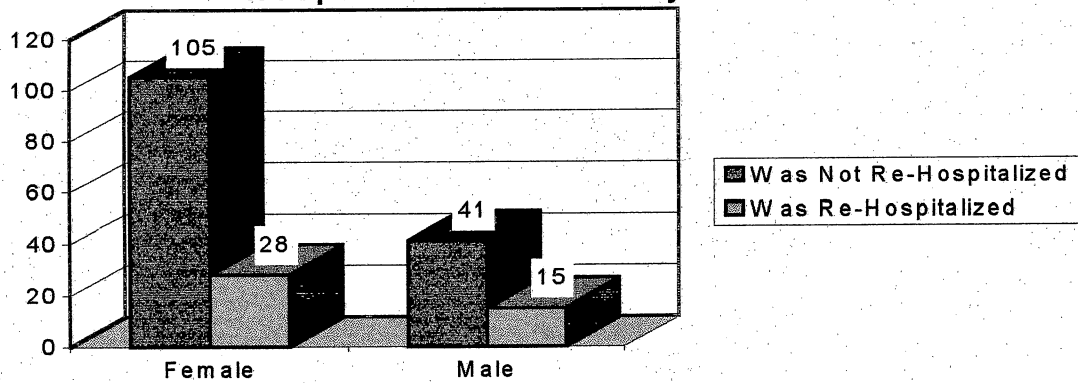


Figure #7
Hospitalization Status by Gender



DISCUSSION

The results showed a statistically significant relationship between in-home health care status and re-hospitalization status. These data substantiate the hypothesis that the provision of in-home health care does mitigate a decline in health status of elderly patients, following discharge from inpatient care and reduces the chances of re-hospitalization.

Proportionately more females received in-home health care services while proportionately more males did not receive in-home health care services. This may be explained by the fact that females statistically live longer than their male counterparts, thus rendering the female population in significantly greater numbers. Consequently females are probably going to proportionately receive more in-home health care. In addition men tend to be older than their wives, this renders the females more likely to be present as care providers.

No significant relationship could be discerned within this sample between gender and re-hospitalization status. At first glance, the numbers might indicate that proportionately more males than females were being re-hospitalized, however this difference is not large enough to be significant. There may actually be a relationship between gender and re-hospitalization status, however a larger sample would reveal more significant data.

This research indicates that there is a positive correlation between receiving in-home health care and lowered re-hospitalization status. It could also be said that receiving in-home health care predisposes a patient to re-hospitalization due to the fact that the patient will be monitored more closely by professionals and may be recognized more quickly than the patient who is not receiving in-home health care services.

Implications for Research and Practice:

For a larger research project it would be important to utilize cost effectiveness and actual utilization of cost specific services as an outcome measurement. Herein will lie the differences between efficacy vs. effectiveness and the actual delivery of in-home health care services. Is this in-home health care efficacious in the actual routine practice to the

patients. It may be that someone in Congress, who thought in-home health care was effective did not consider all the variables and underlying factors that may impede in-home health care services and the delivery of those services.

The whole debate within outcomes research is revolving around the difference between effective research and efficacy research. Research that appeared effective within a specific setting may not actually be efficacious or capable of producing the desired effect when practiced in a different setting.

Measuring outcomes includes keeping track of how many patients need how many services how often. It also includes tracking what expectations are reasonable in regard to patient recovery or return to health. Since outcomes are tied to services and services are defined in terms of resources and costs, the true cost of caring for an elderly patient at home vs. another health care setting requires further research.

As Congress continues to threaten reductions in future health care expenditures and changes to the way in-home health care services are provided, the in-home care industry must be able to speak with one voice. Perhaps now is the time for a major organizational merger to occur. A new association in the in-home care arena that could represent the common interest of the full spectrum of in-home health care providers is needed. As policy makers address a myriad of in-home care service issues, the best form of representation will be an integrated in-home care association that can respond to policy makers with a global view. This group may also assume a leadership role in educating policy makers about the value of in-home care services and in developing future policies that address quality, safety, and ethical modes of conduct.

Research regarding medical and psychosocial outcomes related to the nature and timing of discontinuation of planned in-home health care services will become increasingly important as emphasis shifts to continuity of care models and length of stay (LOS) shortens. Many insurers pay for only short-term in-home health care services or only for such skilled nursing services as dressing changes. Some patients are discharged from the hospital with short term in-home health care services designed only to meet acute medical

needs, leaving more complex medical needs unmet when services are terminated; as a result care is shifted to informal caregivers, emotional health and functional abilities decline and re-hospitalization occurs as medical conditions become acute in the face of insufficient formal supports. These complex issues require further research and evaluation.

Social workers in hospitals will be called on to develop new strategies and programs for ensuring that patients receive planned in-home health care services. With a shift to a community perspective, patients can be assured of services that will enable them to survive and thrive after discharge from in-patient care at a hospital.

Many ethical issues are and will continue to be inherent in the practice of gerontological care. Access to care, rationing of care, managed care, quality of life, especially quality at life's end, the use of advanced directives and adequate informed consent are but a few.

Without radical changes in the way health care is allocated and delivered in this country, the issue of shrinking health care dollars, accessibility to care, increasing commercially managed care, and outright rationing of care will threaten care of elderly persons. Elderly persons will continue to be a high risk for limited access to appropriate and cost effective care. Therefore, it is imperative that innovative cost effective models for care be developed and tested along the continuum of care from prevention of illness to the management of acute illness, to restoration of function, and to maintenance with in-home health care services or management of the patient within the community.

A very proactive stance needs to be taken in the process of advocating for this growing client population. This can be accomplished through knowledge of and involvement in the development of public policies at all levels; local, state, and national, through involvement in legislative action groups, professional organizations, and consumer advocacy groups. Continued advocacy will also be realized through advances in research and social work practice.

There is a growing recognition of the importance of social networks and social supports for increased health benefits. As gerontologists and geriatricians begin to identify the means to increase active and healthy life expectancy, rather than mere life expectancy, it is likely that an elderly person's social networks and social support will be shown even more indispensable to health and successful aging.

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